Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
PAIN AND RECOVERY CLINIC

Respondent Name
AMERICAN ZURICH INSURANCE CO

MFDR Tracking Number
M4-15-3784-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JULY 20, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "After requesting reconsideration in a timely fashion VIA certified mail to Broadspire, it is quite evident that the carrier is unwilling to reimburse our facility for medical bills that were authorized. The services were AUTHORIZED by the precertification department of Broadspire upon peer review and are not subject to retrospective review which clearly violate Texas Labor Code 134.600. We feel that our facility should be paid according to the fee schedule guidelines."

Amount in Dispute: $3,000.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier will stand on the denial of the charges made the basis of this medical fee dispute. There is an existing and ongoing dispute on the extent of the compensable injury. This case is moving to a contested case hearing on the issue of extent. The treatment made the basis of this dispute was not medically necessary for the injuries in dispute."

Response Submitted by: Pappas & Suchma, PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 28, 2015 April 29, 2015 May 1, 2015 May 4, 2015	CPT Code 97799-CP	$3,000.00	$2,400.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the medical fee guidelines for Workers' Compensation Specific Services.

3. 28 Texas Administrative Code §134.600 sets out the guidelines for Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - D-51 – Unnecessary Treatment based on Peer Review.
   - V – Unnecessary Treatment (w/ Peer Review).
   - 18 – Exact Duplicate Claim/Service.
   - 224 – Duplicate Charge.
   - A99 – Appeal/Reconsideration has been received and is currently being reviewed under original bill.
   - W1 – Workers' Compensation Jurisdictional Fee Schedule Adjustment.
   - D00 Based on further review, no additional allowance is warranted.
   - W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. Did the respondent denied the charges bases on the extent of the compensable injury?
2. Did the requestor obtain preauthorization for the services denied for unnecessary medical with a peer review?
3. Is the requestor entitled to reimbursement?

Findings

1. The respondents position summary alludes to an "ongoing dispute on the extent of the compensable injury" and also stating that "This case is moving to a contest case hearing on the issue of extent." There were no denials of extent made on the EOBs submitted by the requestor nor did the insurance carriers' agent provide documentation to support their denial before the requestor submitted the dispute to Medical Fee Dispute Resolution. Therefore the dispute will be reviewed in accordance with applicable rules and the Texas Labor Code.

2. In accordance with 28 Texas Administrative Code §134.600(c) "The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions); (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care; (C) concurrent utilization review of any health care listed in subsection (q) of this section that was approved prior to providing the health care; or (D) when ordered by the commissioner."

   Review of the documentation provided by the health care provider finds that the Chronic Pain Management Program was preauthorized by Broadspire on April 22, 2015 for 80 hours between April 16, 2015 and May 31, 2015. Therefore, the insurance carrier has incorrectly denied the services in dispute and reimbursement is recommended.

3. Per 28 Texas Administrative Code §134.204 "(h)(1)(B) If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR." Per 28 Texas Administrative Code §134.204(h) The following shall be applied for billing and reimbursement of Chronic Pain management/Interdisciplinary Pain Rehabilitation Programs. (A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units' column on the bills. CARF accredited Programs shall ad "CA" as a second Modifier. (B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 115 minute increments. A single 15 minute increment may be billed and reimbursed if great than or equal to eight minutes and less than 23 minutes. Reimbursement for CPT Code 97799-CP is as follows:
   - Date of Service: April 28, 2015: CPT Code 97799-CP, 5 Units. Review of progress notes supports reimbursement at 80% of the MAR for a total of $500.00.
   - Date of Service: April 29, 2015: CPT Code 97799-CP, 5 Units. Review of the progress notes supports reimbursement at 80% of the MAR for a total of $500.00.
   - Date of Service: May 1, 2015: CPT Code 97799-CP, 7 Units. Review of the progress notes supports reimbursement at 80% of the MAR for a total of $700.00.
   - Date of Service: May 2, 2015: CPT Code 97799-CP, 7 Units. Review of the progress notes supports reimbursement at 80% of the MAR for a total of $700.00

   Total reimbursement is $2,400.00

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $2,400.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $2,400.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		November 5, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.